



CLAIM FOR PAYMENT OF COST OF UNAUTHORIZED MEDICAL SERVICES

NOTICE: Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Project Officer (2900-0080), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The information requested on this form is solicited under authority of Title 38, United States Code, "Veterans Benefits," and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.

PART I

1A. VETERAN'S NAME (Last, first, middle initial)	1B. CLAIM NUMBER C-	1C. SOCIAL SECURITY NUMBER
1D. VETERAN'S ADDRESS (Include complete ZIP Code)		
2A. NAME AND ADDRESS OF PERSON, FIRM OR INSTITUTION MAKING CLAIM (Leave blank if same as above)		2B. SOCIAL SECURITY NO. OR EMPLOYEE IDENTIFICATION NO.

3. STATEMENT OF CIRCUMSTANCES UNDER WHICH THE SERVICES WERE RENDERED (Include diagnosis, symptoms, whether emergency existed, and reason VA facilities were not used)

4. AMOUNT CLAIMED \$	Attach bills or receipts showing services furnished, dates and charges
5. COMPLETE A OR B AS APPROPRIATE	
A. Amount charged does not exceed that charged the general public for similar services. Payment has not been received.	B. I certify that the amount claimed has been paid and reimbursement has not been received.
SIGNATURE AND TITLE OF PROVIDER OF SERVICE AND DATE	SIGNATURE OF VETERAN OR REPRESENTATIVE AND DATE

PART II - FOR VETERANS AFFAIRS USE ONLY

6. ACTION <input type="checkbox"/> APPROVED \$ <input type="checkbox"/> DISAPPROVED	CLAIM MEETS THE REQUIREMENTS OF VA REGULATION <input type="checkbox"/> 6080 <input type="checkbox"/> 6081	
7. SIGNATURE OF CHIEF, MEDICAL ADMINISTRATION SERVICE	8. DATE	9. ADMINISTRATIVE VOUCHER NUMBER